DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G214	A. BUILDING _____ B. WING _____	C 05/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	5701 14TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On 5/13/2008, the Department of Health received notice of Client #1's death. The information obtained revealed that on 4/2/2008, Client #1 was hospitalized due to unresponsiveness. Client #1 was transported to the Emergency Room (ER) and was admitted for emergent care. Client #1 passed away on the morning of 5/13/2008. The cause of death remains unknown to date. Upon her admission to Metro Homes on 3/3/2008, Client #1 was diagnosed with the following medical conditions: Congenital heart disease (mitral valve), VSD, HBV carrier, S/P Mastoidectomy 1986, B/L Cataracts, abnormal gait, B/L Pes Planus, Seborrheic dermatitis, Scoliosis, Chronic Otitis Media, Severe Esophageal Motility D/O, H/O silent aspiration, Onychomychosis, S/P Blepharitis, H/O Left knee cellulitis, Subluxation deformity of the left thumb, S/P polyectomy, Osteoarthritis, Myopia, mild Hyperproliferative bone marrow, H/O Macrocytosis, Leucopenia right thumb fusion, Athlete ' s foot, recurrent UTI, Hypokalemia. Due to the nature of this incident, an on-site investigation was initiated on 5/22/2008. At the conclusion of the survey, there were evidence and incidental findings to support that the facility was out of compliance with a few standard level regulatory requirements. The deficiencies identified in this report were based on interviews with the nursing staff, management staff, direct care staff and record reviews. The findings were also based on a review of the clinical and medical records as well a review of the unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY	W 104		

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HEALTH REGULATION
ADMINISTRATION
2008 JUL -2 A 7:46

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ADMINISTRATION
2008 JUN 32 A 7:45

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan L. Sloan RN, BSN, MA | TITLE: VP-Operations | (X6) DATE: 6/30/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure changes to their policies to address medical provisions that would ensure clients health and safety. The finding includes: Client #1 was admitted to the facility on 3/3/2008 without a complete medical history being made available. Apparently, Client #1 ' s medical history was later found to include the diagnoses of MRSA. It is not clear exactly when the facility received this information, but preventive measures were enacted to ensure the health and safety of the remaining residents in 5/22/2008 and all residents were tested for and found negative of MRSA. On 5/22/2008 at 1:23pm, the facility ' s Qualified Mental Retardation Professional (QMRP) revealed the policies were being revised to address the MRSA problem and to ensure that these assessments for communicable diseases could be addressed prior to admission. The facility conducted an internal investigation into the situation on 5/19/2008 and concluded: " Metro Homes should amend or modify its Admission Policy to include that all individuals transferred directly from long term care at hospitals and nursing homes are tested for MRSA. In order to treat individuals immediately and prevent infection of others, "	W 104	W 104 The Agency was in conversation with Dr. Bullock from Providence Hospital in regards to the MRSA episodes with hospitalized clients. On 6/25/08 we received confirmation that Providence Hospital had instituted a MRSA screening Policy for all in patients. The Agency has now amended its admission policy to include the MRSA screening. See attached Providence Hospital Policy and Metro Homes policy.	6/25/08

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W 104	Continued From page 2 A secondary interview with the facility ' s Registered Nurse Supervisor on 5/30/2008 revealed that the changes in the admission policy to address MRSA and other communicable diseases were still pending. Additional record review on 5/30/2008 revealed that all five of the remaining residents were tested on 5/22/2008 for MRSA and were tested to be negative. There was no evidence presented or on file at the time of survey to substantiate that the policies were amended as recommended to ensure the health and safety of its residents.	W 104		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was effectively trained to ensure client ' s health and safety as outlined in their habilitation plans. [Client #1] The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP), House Manager (HM), and direct care staff on 5/22/2008 revealed Client #1 sustained a fall from her wheelchair on 3/26/2008. Record review on 5/22/2008 reflected this event did occur as garnered during the interviews. Additional record review revealed the facility failed to ensure that all staff had received training on Client #1 ' s " Fall Prevention Protocol " prior to	W 189	W 189 All clients who are wheelchair bound or who have an unsteady gait have a fall assessment completed. The HMCP reflects the preventive measures to be taken for falls. The staff are trained on each individuals fall protocol. See attached training on Falls Protocol.	6/25/08

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W 189	Continued From page 3 her fall. In addition, the facility failed to ensure that all staff received training on said protocol after the incident as well. There was no evidence on file or presented at the time of survey to substantiate that the facility employed effective staff training measures to ensure Client #1 ' s health and safety with regards to fall prevention prior to the occurrence of the incident. [Cross Reference W249]	W 189		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure its staff was capable of implementing preventive measures to protect a client ' s health and safety as outlined in the habilitation plan for one of five clients residing in the facility. [Client #1] The finding includes: Record review on 5/22/2008 and again on 5/30/2008 revealed Client #1 was diagnosed to have Osteoporosis and Osteopenia. Additional record review revealed Client #1 sustained a fall from her wheel chair on 3/26/2008. Interview with the facility ' s House Manager (HM) on 5/22/2008 revealed she was in the dining area when she heard Client #1 fall in the living room. Both she and the incident report indicated a pillow was placed in front of Client #1 ' s chair as a preventive measure prior to the fall. It must be noted, the facility ' s main floor is hardwood and it	W 194	W 194 The client was not sitting in her wheelchair and was not alone during the time of the incident. She was sitting in a regular single seated sofa and was being assessed by the Speech Therapist during the time of the incident. The client had a bed standard size pillow placed in front of her when she was seated in the sofa. She did not have a fall but rather slid onto the floor from the 1.0 foot high sofa chair, which belonged to the client, and landed on the pillow. She sustained no overt injuries and proper protocol was followed after the incident.	

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W 194	Continued From page 4 is not clear how large a pillow was placed in front of Client #1 ' s chair. Further record review revealed Client #1 was provided with a " Fall Prevention Protocol " [FPP] to prevent such an event. The document outlines that: "Staff will assist her to sit in her chair only if someone is sitting next to her for as long as she is in the chair. A pillow is advisable to be placed at the foot of her chair when she is in it ... Staff will assist her to sit in her wheelchair and ensuring that her brakes are put on and off appropriately and the straps are fastened whenever she is in the wheelchair. " The facility conducted an internal investigation into the fall and recommended that staff be retrained to implement the FPP, but failed to clarify or address why Client #1 was left alone in the living room or if her " straps " were properly employed when she was sitting in the chair prior to her fall.	W 194	The Incident Management Coordinator failed to interview the Speech Therapist or get her statement. In the future the IMC will ensure all persons witnessing an incident are adequately interviewed and appropriate statements are written to reflect actual facts. See attached Speech Therapist's statement	6/27/08
W 200	483.440(b)(3) ADMISSIONS, TRANSFERS, DISCHARGE A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to acquire all pertinent medical records prior to admitting a client for care. [Client #1]	W 200		

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W 200	Continued From page 5 The finding includes: Interview with the facility ' s Licensed Practical Nurse on the afternoon of 5/22/2008 revealed she was not aware Client #1 had a history of seizures prior to her admission on 3/3/2008. Furthermore, a secondary interview with the facility ' s Registered Nurse (RN) Supervisor on the afternoon of 5/30/2008 supported the original finding. According to the RN Supervisor, the facility did not receive Client #1 ' s hospitalization records until several weeks after her admission (delivery date unknown). The Registered Nurse (RN) recalls that the only document provided to the facility at the time of admission were the discharge documentation from the hospital she was being released from. She further indicated the medical records that were transferred with Client #1 were sparse and incomplete at best. Record review on 5/22/2008 revealed Client #1 ' s admission documents did not reflect that she had a history of seizure/seizure disorder. In addition, the most recent Physician ' s Order Sheet dated 5/2008 also did not list Seizure and/or Seizure Disorder as part of Client #1 ' s medical profile. A secondary record review was conducted on 5/30/2008 and additional documents were provided at that time. The documents that were presented revealed that " shortly after her admission to Providence Hospital [Client #1] experienced an onset of seizure activity. " The resulting findings and tests resulted in " [Client #1] being prescribed Kepra 250 mg IV BID " per the recommendation of the attending Neurologist at Providence Hospital. Other hospitalizations on record reveal the following medical history: 1. 12/25/2007 - Hyperkalemia and seizure	W 200	W 200 At the time of the admission the DON and the VP of Operations had a conversation with the discharging Physician from her previous agency, Dr. Potts. He absolutely refuted the diagnosis of seizure disorder although the ER had mentioned it on 2 occasions – 8/03/07 and 12/25/07. The Primary Care Physician would not confirm the diagnosis of Seizure Disorder till she was seen and diagnosed by a Neurologist. However he deferred a neurology consult as she had no neurological deficits seen. Hence the diagnosis and treatment were not included on the physicians order sheets.	6/28/08

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W 200	Continued From page 6 activity 2. 12/16/2007 - Treated for altered mental status. 3. 11/05/2007 - Treated for Urinary Tract Infection (UTI). 4. 08/03/2007 - Treated for Hypokalemia, UTI and for seizure activity. It is not clear if Client #1 ' s hospitalization on 4/2/2008 was related to her fluctuating Potassium levels, seizure activity or both. It is also not clear if the facility was aware of Client #1 having a history of fluctuating mineral levels and seizures prior to admission. What was ascertained was that the medical records were incomplete and the facility did not have a clear picture of Client #1 ' s health at the time of admission and was only providing care based on the information they had on record at the time. [Cross Reference W104]	W 200		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the proper and necessary medical follow-up to ensure a client ' s health and safety. The finding includes: Record review on 5/22/2008 and again on 5/30/2008 revealed Client #1 has been diagnosed to have Osteoporosis and Osteopenia. Additional record review revealed Client #1 sustained a fall from her wheel chair on 3/26/2008. Interview with	W 322	W 322 After the fall the Primary Care Physician did not order any radiological services as the client did not fall but slid unto the pillow on the floor. She did not sustain any injuries and the PCP did not recommend radiology. The PCP did however order a wheelchair assessment and a chest harness.	6/25/08

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W 322	Continued From page 7 the facility ' s House Manager (HM) on 5/22/2008 revealed she was in the dining area when she heard Client #1 fall in the living room. At that time, staff rushed to her aid to check on her condition, notified the nurse on duty and Client #1 was later assessed to be without injury. Both the House Manager (HM) and the incident report detailed that a pillow was placed in front of Client #1 ' s chair as a preventive measure prior to the fall. It must be noted, the facility ' s main floor is hardwood and it is not clear how large a pillow was placed in front of Client #1 ' s chair. Further record review revealed Client #1 was provided with a " Fall Prevention Protocol " to prevent such an event. The facility conducted an internal investigation into the fall and concluded "[Client #1] may have benefited from Radiological services immediately following her fall out of her wheelchair on March 26, 2008 given her severe Osteoporosis and Osteopenia." There was no evidence presented or on file at the time of inspection to substantiate that given the known diagnosis of Osteoporosis / Osteopenia, the medical team took preventive measures to ensure and validate that she was without injury. In addition, the recommendation for radiological services after the fall to ensure that this client ' s health and safety was intact was never completed.	W 322		
W 341	483.460(c)(5)(ii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control.	W 341		

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W 341	Continued From page 8 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was trained to manage and care for clients who have been diagnosed with having communicable diseases. [Client #1] The finding includes: Interview with the facility ' s Registered Nurse Supervisor on 5/30/2008 revealed Client #1 was admitted to the facility without a complete medical history being made available. Client #1 ' s medical history was later found to include the diagnoses of MRSA. It is not clear exactly when the facility received this information, but the RN Supervisor stated that preventive measures were enacted to ensure the health and safety of the remaining residents and all clients were tested for MRSA on 5/22/2008 and were found to be negative. Further staff interview revealed the facility ' s policies were in process of being revised to include the management of MRSA. Additional record review revealed the facility did not train staff when they received notification that Client #1 was diagnosed with MRSA, nor have they trained staff to date to manage individuals who may have or are diagnosed with having MRSA. A final interview with the facility ' s Registered Nurse Supervisor on 5/22/2008 at 2:27pm revealed " only the nurses [were] responsible for caring for that skin condition " . In addition, she stated that staff was trained to address that problem, but the evidence of the training was with the former Qualified Mental Retardation Professional	W 341	W 341 The Agency nurse was made aware of the MRSA diagnosis on 5/2/08. All clients were tested for MRSA and found to be negative; therefore there was no training for MRSA done for the staff. In the future the agency RN will ensure that MRSA training is completed for all clients who have been hospitalized in each facility.	6/2/08

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W 341	Continued From page 9 (QMRP) who was no longer employed by the company. There was no evidence on file or presented at the time of survey to substantiate that staff were trained to manage MRSA.	W 341		

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I 000	INITIAL COMMENTS On 5/13/2008, the Department of Health received notice of Resident #1's death. The information obtained revealed that on 4/2/2008, Resident #1 was hospitalized due to unresponsiveness. Resident #1 was transported to the Emergency Room (ER) and was admitted for emergent care. Resident #1 passed away on the morning of 5/13/2008. The cause of death remains unknown to date. Upon her admission to Metro Homes on 3/3/2008, Resident #1 was diagnosed with the following medical conditions: Congenital heart disease (mitral valve), VSD, HBV carrier, S/P Mastoidectomy 1986, B/L Cataracts, abnormal gait, B/L Pes Planus, Seborrheic dermatitis, Scoliosis, Chronic Otitis Media, Severe Esophageal Motility D/O, H/O silent aspiration, Onychomychosis, S/P Blepharitis, H/O Left knee cellulitis, Subluxation deformity of the left thumb, S/P polyectomy, Osteoarthritis, Myopia, mild Hyperproliferative bone marrow, H/O Macrocytosis, Leucopenia right thumb fusion, Athlete ' s foot, recurrent UTI, Hypokalemia. Due to the nature of this incident, an on-site investigation was initiated on 5/22/2008. At the conclusion of the survey, there were evidence and incidental findings to support that the facility was out of compliance with a few standard level regulatory requirements. The deficiencies identified in this report were based on interviews with the nursing staff, management staff, direct care staff and record reviews. The findings were also based on a review of the clinical and medical records as well a review of the unusual incident reports.	I 000		

Health Regulation Administration

Susan J. Sloan RN, BSN, MA — VP-Operations — 6/30/08
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 222	Continued From page 1	I 222		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff received training to ensure resident ' s health and safety as outlined in their habilitation plans. [Resident #1] The finding includes: The facility failed to ensure its staff was prepared and trained to manage communicable diseases. [Reference 3510.5(c)]	I 222	I 222 refer to W 341	
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was effectively trained to manage communicable diseases. [Resident #1] The finding includes: Interview with the facility ' s Registered Nurse Supervisor on 5/30/2008 revealed Resident #1 was admitted to the facility without a complete medical history being made available. Resident #1 ' s medical history was later found to include the diagnoses of MRSA. It is not clear exactly when the facility received this information, but the RN Supervisor stated that preventive measures were enacted to ensure the health and safety of the remaining residents and all residents were tested for MRSA on	I 226	I 226 Refer to W 341	

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	HFD03-0227	A. BUILDING _____ B. WING _____	05/30/2008

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METRO HOMES, INC	5701 14TH STREET, NW WASHINGTON, DC 20011

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I 226	Continued From page 2 5/22/2008 and were found to be negative. Further staff interview revealed the facility ' s policies were in process of being revised to include the management of MRSA. Additional record review revealed the facility did not train staff when they received notification that Resident #1 was diagnosed with MRSA, nor have they trained staff to date to manage individuals who may have or are diagnosed with having MRSA. A final interview with the facility ' s Registered Nurse Supervisor on 5/22/2008 at 2:27pm revealed " only the nurses [were] responsible for caring for that skin condition " . In addition, she stated that staff was trained to address that problem, but the evidence of the training was with the former Qualified Mental Retardation Professional (QMRP) who was no longer employed by the company. There was no evidence on file or presented at the time of survey to substantiate that staff were trained to manage MRSA.	I 226		
I 310	3516.1 ADMIT, TRANSFER, DISCHARGE: GENERAL PROVISION Each GHMRP shall have written policies, which clearly describe its admission, transfer and discharge criteria and procedures. This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to ensure changes to their policies to address medical provisions that would ensure residents health and safety. The finding includes: Resident #1 was admitted to the facility on 3/3/2008 without a complete medical history	I 310		

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I 310	Continued From page 3 being made available. Apparently, Resident #1 ' s medical history was later found to include the diagnoses of MRSA. It is not clear exactly when the facility received this information, but preventive measures were enacted to ensure the health and safety of the remaining residents in 5/22/2008 and all residents were tested for and found negative of MRSA. On 5/22/2008 at 1:23pm, the facility ' s Qualified Mental Retardation Professional (QMRP) revealed the policies were being revised to address the MRSA problem and to ensure that these assessments for communicable diseases could be addressed prior to admission. The facility conducted an internal investigation into the situation on 5/19/2008 and concluded: " Metro Homes should amend or modify its Admission Policy to include that all individuals transferred directly from long term care at hospitals and nursing homes are tested for MRSA. In order to treat individuals immediately and prevent infection of others. " A secondary interview with the facility ' s Registered Nurse Supervisor on 5/30/2008 revealed that the changes in the admission policy to address MRSA and other communicable diseases were still pending. Additional record review on 5/30/2008 revealed that all five of the remaining residents were tested on 5/22/2008 for MRSA and were tested to be negative. There was no evidence presented or on file at the time of survey to substantiate that the policies were amended as recommended to ensure the health and safety of its residents.	I 310	I 310 The Agency was in conversation with Dr. Bullock from Providence Hospital in regards to the MRSA episodes with hospitalized clients. On 6/25/08 we received confirmation that Providence Hospital has instituted a MRSA screening Policy for all in patients. The Agency has now amended it's admission policy to include the MRSA screening. See attached Providence Hospital Policy and Metro Homes policy.	6/25/08
I 322	3517.3 ADMISSION POLICIES PROCEDURES	I 322		

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I 322	Continued From page 4 Each GHMRP shall obtain from the resident, sponsoring agency or guardian, as appropriate, information about any known health problems communicable disease of a resident upon his or her being admitted or readmitted. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to acquire all pertinent medical records prior to admitting a resident for care. [Resident #1] The finding includes: Interview with the facility ' s Licensed Practical Nurse on the afternoon of 5/22/2008 revealed she was not aware Resident #1 had a history of seizures prior to her admission on 3/3/2008. Furthermore, a secondary interview with the facility ' s Registered Nurse (RN) Supervisor on the afternoon of 5/30/2008 supported the original finding. According to the RN Supervisor, the facility did not receive Resident #1 ' s hospitalization records until several weeks after her admission (delivery date unknown). The Registered Nurse (RN) recalls that the only document provided to the facility at the time of admission were the discharge documentation from the hospital she was being released from. She further indicated the medical records that were transferred with Resident #1 were sparse and incomplete at best. Record review on 5/22/2008 revealed Resident #1 ' s admission documents did not reflect that she had a history of seizure/seizure disorder. In addition, the most recent Physician ' s Order Sheet dated 5/2008 also did not list Seizure and/or Seizure Disorder as part of Resident #1 ' s medical profile. A secondary record review was conducted on 5/30/2008 and additional documents were	I 322	I 322 At the time of the admission the DON and the VP of Operations had a conversation with the discharging Physician from her previous agency. He absolutely refuted the diagnosis of seizure disorder although the ER had mentioned it on 2 occasions – 8/03/07 and 12/25/07. The Primary Care Physician would not confirm the diagnosis of Seizure Disorder till she was seen and diagnosed by a Neurologist. Hence the diagnosis and treatment were not included on the physicians order sheets.	6/28/08

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I 322	Continued From page 5 provided at that time. The documents that were presented revealed that " shortly after her admission to Providence Hospital [Resident #1] experienced an onset of seizure activity. " The resulting findings and tests resulted in " [Resident #1] being prescribed Kepra 250 mg IV BID " per the recommendation of the attending Neurologist at Providence Hospital. Other hospitalizations on record reveal the following medical history: 1. 12/25/2007 - Hyperkalemia and seizure activity 2. 12/16/2007 - Treated for altered mental status. 3. 11/05/2007 - Treated for Urinary Tract Infection (UTI). 4. 08/03/2007 - Treated for Hypokalemia, UTI and for seizure activity. It is not clear if Resident #1 ' s hospitalization on 4/2/2008 was related to her fluctuating Potassium levels, seizure activity or both. It is also not clear if the facility was aware of Resident #1 having a history of fluctuating mineral levels and seizures prior to admission. What was ascertained was that the medical records were incomplete and the facility did not have a clear picture of Resident #1 ' s health at the time of admission and was only providing care based on the information they had on record at the time. [Cross Reference W104]	I 322		
I 330	3517.8 ADMISSION POLICIES PROCEDURES Each GHMRP shall secure a physician ' s written report of the health inventory, which shall provide sufficient information concerning the resident ' s health including treatment, special diet, or medication orders to enable the GHMRP to provide appropriate services.	I 330		

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I 330	Continued From page 6 This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to acquire all pertinent medical records prior to admitting a resident for care and failed to address a resident ' s history of seizure activity. [Resident #1] The finding includes: The facility failed to ensure that a full and complete health inventory included Resident #1 ' s history of seizures / seizure activity. The diagnosis was neither addressed and/or treated for. [Reference 3517.3]	I 330		6/27/08
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff implemented preventive measures as outlined in a resident ' s habilitation records to ensure a resident ' s health and safety. The finding includes: Record review on 5/22/2008 and again on 5/30/2008 revealed Resident #1 was diagnosed to have Osteoporosis and Osteopenia. Additional record review revealed Resident #1 sustained a fall from her wheel chair on 3/26/2008. Interview with the facility ' s House Manager (HM) on 5/22/2008 revealed she was in the dining area when she heard Resident #1 fall in the living room. Both she and the incident report indicated	I 422	I 422 The client was not sitting in her wheelchair and was not alone during the time of the incident. She was sitting in a regular single seated sofa which was hers. The client had a bed standard pillow placed in front of her when she was seated in the sofa. She did not have a fall but rather slid onto the floor from the 1.5 foot high sofa, and landed on the pillow. She sustained no overt injuries and proper protocol was followed after the incident.	

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I 422	Continued From page 7 a pillow was placed in front of Resident #1 ' s chair as a preventive measure prior to the fall. It must be noted, the facility ' s main floor is hardwood and it is not clear how large a pillow was placed in front of Resident #1 ' s chair. Further record review revealed Resident #1 was provided with a " Fall Prevention Protocol " [FPP] to prevent such an event. The document outlines that: "Staff will assist her to sit in her chair only if someone is sitting next to her for as long as she is in the chair. A pillow is advisable to be placed at the foot of her chair when she is in it ... Staff will assist her to sit in her wheelchair and ensuring that her brakes are put on and off appropriately and the straps are fastened whenever she is in the wheelchair. " The facility conducted an internal investigation into the fall and recommended that staff be retrained to implement the FPP, but failed to clarify or address why Resident #1 was left alone in the living room or if her " straps " were properly employed when she was sitting in the chair prior to her fall.	I 422	The Incident Management Coordinator failed to interview the Speech Therapist or get her statement. In the future the IMC will ensure all persons witnessing an incident are adequately interviewed and appropriate statements are written to reflect actual facts. See attached Speech Therapists statement	